

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1711

01691

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064

I

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CALVERT</u> <span style="float: right;">b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK 1WK.</u></span> c. LENGTH OF STAY IN 1b <u>ISLAND CREEK, MD.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CALVERT COUNTY HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD.</u> <span style="float: right;">b. COUNTY <u>CALVERT</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES R. BELT</u>			<b>4. DATE OF DEATH</b> Month <u>FEB.</u> Day <u>7</u> Year <u>1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1899</u>		9. AGE (In years last birthday) <u>62</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED BLDG CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CALVERT CO., MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES R. BELT</u>			14. MOTHER'S MAIDEN NAME <u>HELEN M. DUKE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-34-0056</u>		17. INFORMANT <u>MRS HELEN ROONEY - ISLAND CREEK, MD</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of COLON (SPLEENIC FLEW)</u> 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this Hospital) attended the deceased from <u>Feb 6</u> , 19 <u>61</u> , to <u>Feb 7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>PAGE C. JETT</u>			22b. DATE SIGNED <u>2/7/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>PRINCE FREDERICK MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH CEM. CALVERT CO., MD</u>			
24. BURIAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Ind.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911

1911

1

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01692

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jefferie A. Brooks</i>		4. DATE OF DEATH Month <i>2</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/9/60</i>
9. AGE (In years last birthday) yrs. <i>1</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Calvin Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Sammy Lydia Mack</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Calvin Brooks</i>		Address <i>Princeton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>917.0 Herma from burn of leg</i> DUE TO <i>body when</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>body when</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Part A coffee was knocked over on her</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>5</i> p. m. <i>2</i> <i>10</i> <i>1961</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Calvert</i>	
21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. <i>Quincy</i>	
PHYSICIAN'S NAME (Type) <i>H W Ward</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-12-61</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Plum Point</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		ADDRESS <i>Prince Frederick</i>	
24a. REC'D BY REGISTRAR <i>FEB 14 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

1912

TALENT BOARD

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>
DATE OF DEATH <i>Jan 15 1912</i>		PLACE OF DEATH <i>Home</i>	CAUSE OF DEATH <i>Heart Disease</i>	
DISEASE OR INJURY <i>Myocarditis</i>		PERIOD OF ILLNESS <i>2 weeks</i>	MANNER OF DEATH <i>Natural</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		DATE OF BIRTH <i>Dec 10 1866</i>	OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	MARRIED <i>Yes</i>	
SPOUSE'S NAME <i>John A. Smith</i>		DATE OF MARRIAGE <i>Jan 10 1890</i>	CHILDREN <i>3</i>	
FATHER'S NAME <i>John A. Smith</i>		MOTHER'S NAME <i>John A. Smith</i>	BLOOD RELATIONSHIP <i>None</i>	
SIGNATURE OF DECEASED <i>John A. Smith</i>		SIGNATURE OF WITNESSES <i>John A. Smith</i>		
SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		SIGNATURE OF CORONER <i>John A. Smith</i>		
SIGNATURE OF JURY <i>John A. Smith</i>		SIGNATURE OF JUDGE <i>John A. Smith</i>		
SIGNATURE OF CLERK <i>John A. Smith</i>		SIGNATURE OF REGISTRAR <i>John A. Smith</i>		

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1713

## CERTIFICATE OF DEATH

Reg. Dist. No.

01693

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>215 Bay Ave</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i> d. STREET ADDRESS <i>1 215 Bay Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alroy S. Chrismond</i> First Middle Last				4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1961</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 3, 1870</i>	
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>		11. BIRTHPLACE (State or foreign country) <i>West Va</i>	
13. FATHER'S NAME <i>Oscar Chrismond</i>				14. MOTHER'S MAIDEN NAME <i>Jean Leannon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>B. S. Weir, N. Beach Md</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular and disease</i> <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Had cancer of left ear</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had an old wound on arm</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>50</i> , to <i>Feb</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>2/23/61</i> , 19 <i>61</i> , and that death occurred at <i>4:50</i> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>H W Ward</i> M.D. <i>Oving Md</i> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>2-28-61</i>		<i>FORT LINCOLN</i>		<i>BLADENSBURG. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W W Chambers Co. 517 11th St. S.E. DC</i>				24a. REC'D BY REGISTRAR <i>FEB 28 '61</i>		24b. REGISTRAR'S SIGNATURE <i>William J. Howard</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1913

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Duration of illness	
9. Name of physician		10. Name of funeral director		11. Name of undertaker		12. Name of cemetery	
13. Name of registrar		14. Name of witness		15. Name of witness		16. Name of witness	
17. Name of witness		18. Name of witness		19. Name of witness		20. Name of witness	
21. Name of witness		22. Name of witness		23. Name of witness		24. Name of witness	
25. Name of witness		26. Name of witness		27. Name of witness		28. Name of witness	
29. Name of witness		30. Name of witness		31. Name of witness		32. Name of witness	
33. Name of witness		34. Name of witness		35. Name of witness		36. Name of witness	
37. Name of witness		38. Name of witness		39. Name of witness		40. Name of witness	
41. Name of witness		42. Name of witness		43. Name of witness		44. Name of witness	
45. Name of witness		46. Name of witness		47. Name of witness		48. Name of witness	
49. Name of witness		50. Name of witness		51. Name of witness		52. Name of witness	
53. Name of witness		54. Name of witness		55. Name of witness		56. Name of witness	
57. Name of witness		58. Name of witness		59. Name of witness		60. Name of witness	
61. Name of witness		62. Name of witness		63. Name of witness		64. Name of witness	
65. Name of witness		66. Name of witness		67. Name of witness		68. Name of witness	
69. Name of witness		70. Name of witness		71. Name of witness		72. Name of witness	
73. Name of witness		74. Name of witness		75. Name of witness		76. Name of witness	
77. Name of witness		78. Name of witness		79. Name of witness		80. Name of witness	
81. Name of witness		82. Name of witness		83. Name of witness		84. Name of witness	
85. Name of witness		86. Name of witness		87. Name of witness		88. Name of witness	
89. Name of witness		90. Name of witness		91. Name of witness		92. Name of witness	
93. Name of witness		94. Name of witness		95. Name of witness		96. Name of witness	
97. Name of witness		98. Name of witness		99. Name of witness		100. Name of witness	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1714

## CERTIFICATE OF DEATH

01694

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">CALVERT</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">PRINCE FREDERICK</span> <span style="float: right;">2 WKS</span> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">CALVERT COUNTY HOSPITAL</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <span style="font-size: 1.5em;">MD</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.5em;">CALVERT</span></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">X HUNTINGTOWN</span> d. STREET ADDRESS <span style="font-size: 1.5em;">1</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">JANIE ELIZABETH GIBSON</span> First Middle Last <b>5. SEX</b> <span style="font-size: 1.5em;">F</span> <b>6. COLOR OR RACE</b> <span style="font-size: 1.5em;">W</span> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">MAY 30, 1876</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">84</span> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				<b>4. DATE OF DEATH</b> <span style="font-size: 1.2em;">Feb. 21, 1961</span> Month Day Year			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">HOME</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">HUNTINGTOWN, MD</span>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="font-size: 1.5em;">U.S.A.</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">JOSEPH R. GIBSON</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ANNIE MARY SHECKELS</span>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.5em;">UNKNOWN</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">WALTER GIBSON - HUNTINGTOWN, MD.</span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Cardiac Decompensation</span> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">Arteriosclerosis of disease</span> DUE TO (c) <span style="font-size: 1.2em;">Fracture of left hip</span> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">48 hours</span> <span style="font-size: 1.2em;">10 years</span>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.5em;">Fall in home</span>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <span style="font-size: 1.2em;">12 Nov 2/8 1961</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.5em;">Home</span>			
<b>20f. (City or town)</b> <span style="font-size: 1.5em;">Huntingtown - Calvert - Md.</span>		<b>20g. (County)</b> <span style="font-size: 1.5em;">Calvert</span>					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2-8</span> 19 <span style="font-size: 1.2em;">61</span> to <span style="font-size: 1.2em;">2-21</span> 19 <span style="font-size: 1.2em;">61</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">2-21</span> 19 <span style="font-size: 1.2em;">61</span> , and that death occurred at <span style="font-size: 1.2em;">11:55 PM</span> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <span style="font-size: 1.5em;">Page C. Jett</span>				<b>22b. DATE SIGNED</b> <span style="font-size: 1.2em;">2/22/61</span>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Page C. Jett</span>				<b>22d. ADDRESS</b> <span style="font-size: 1.2em;">Prince Frederick, Maryland</span>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.5em;">BURIAL</span>		<b>23b. DATE THEREOF</b> <span style="font-size: 1.2em;">Feb. 24, 1961</span>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">MIRANDA CEMETERY</span>			
<b>23d. LOCATION</b> (City, town or county) <span style="font-size: 1.5em;">HUNTINGTOWN - MD.</span>		<b>23e. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">FEB 27 '61</span>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">A.A. HARKNESS &amp; SON - MUTUAL, MD.</span>				<b>25. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Frank</span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



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FEBRUARY 10 1944  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1715

Item 1d Film G282 3/7/61

01695

1. PLACE OF DEATH a. COUNTY <b>CALVERT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CALVERT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>53 da</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOLA</b> Middle <b>MAE</b> Last <b>HARDESTY</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 24, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL B. PARKER</b>		14. MOTHER'S MAIDEN NAME <b>EMILY MAE STERLING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>NORRIS G. HARDESTY - ST. LEONARDS, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary - to liver</b> DUE TO (b) <b>from Ca of senile of uterus jaundice</b> DUE TO (c) <b>lying cause last.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>18</b> to <b>July 27, 61</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>10:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R de Villalobos</b>		22b. DATE SIGNED <b>2/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R de Villalobos</b>		22d. ADDRESS <b>St Leonard, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WATER'S MEMORIAL</b>		23d. LOCATION (City, town, or county) (State) <b>ISLAND CREEK, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A.A. HARKNESS &amp; SON - MUTUAL, MD</b>		25a. REC'D BY REGISTRAR <b>MAR 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

AMERICAN DEPARTMENT OF HEALTH  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

7-11-63

100-100000

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1716  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01696

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Plum Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Co. Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Holland</u> Last <u>Holland</u>				4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1903</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>57</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			
13. FATHER'S NAME <u>Joseph Holland</u>				14. MOTHER'S MAIDEN NAME <u>Hula Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-01-8082</u>		17. INFORMANT <u>Beatrice Holland Huntington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>7:16 PM</u> 19 <u>61</u> to <u>7:13</u> 19 <u>61</u> , that (I) (we) lost <u>the deceased</u> alive on <u>19</u> and that death occurred at <u>7:13</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Page Jett</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				22d. ADDRESS <u>PRINCE FREDERICK</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-8-61</u>		23b. DATE THEREOF <u>2-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Edmonds</u>		23d. LOCATION (City, town, or county) (State) <u>Sunderland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>				ADDRESS <u>Prince Frederick</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1010

CERTIFICATE OF DEATH

1918

*[Faint, illegible text and markings on a death certificate form, including fields for name, date, and cause of death.]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01697

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Huff</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 6, 1899</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Huff</u>				14. MOTHER'S MARDEN NAME <u>Henrietta Benson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-48-5461</u>		17. INFORMANT <u>Ala Huff</u> Address <u>Huntingtown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident.</u> 231X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> 19 <u>60</u> to <u>2-10</u> 19 <u>61</u> , that (I) (we) lost the deceased alive on <u>2-10</u> 19 <u>61</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. J. Weems</u>				22b. DATE SIGNED <u>2/10/61</u>		22c. PHYSICIAN'S NAME (Type) <u>G. J. Weems</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u>				23e. REGISTRAR <u>Arthur S. Thomas</u>		23f. DATE <u>2/14/61</u>	



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01698

1. PLACE OF DEATH a. COUNTY <b>CALVERT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CALVERT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE FREDERICK</b>				c. LENGTH OF STAY IN 1b <b>2 Mos.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CALVERT COUNTY HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PLUM POINT, HUNTINGTOWN, MD.</b>			
3. NAME OF DECEASED (Type or print) <b>FLORENCE MILDRED MEDAIRD JONES</b>				d. STREET ADDRESS <b>-</b>			
5. SEX <b>F</b>				6. COLOR OR RACE <b>W</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Nov. 27, 1893</b>			
9. AGE (In years last birthday) <b>67</b> yrs.				IF UNDER 1 YEAR: Months <b>17</b> Days <b>19</b> Year <b>1961</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>SUMMERFIELD MEDAIRD</b>				14. MOTHER'S MAIDEN NAME <b>RACHEL GILMORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>			
17. INFORMANT <b>OWEN H. JONES - HUNTINGTOWN, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma of Brain</b> 219X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypernephroma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 17, 1961</b> to <b>Feb 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 17, 1961</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Page C. Jett</b>				22b. DATE SIGNED <b>2/19/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>PAGE C. JETT</b>				22d. ADDRESS <b>PRINCE FREDERICK</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>FEB. 20, 1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>EMMANUEL CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>PLUM POINT, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. G. Harkness &amp; Son - Mutual, Ind.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 21 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

01234

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Handwritten notes and signatures at the bottom of the page, including a large signature and the date 11/11/11.

1719  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 01699

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lusby, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Lee</u> Last <u>hee</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-61</u>	9. AGE (In years lost birthday) yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		IF UNDER 24 HRS. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas H Lee</u>				14. MOTHER'S MAIDEN NAME <u>mae Beverly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas H. Lee, Lusby, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (2 lb)</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>776X</u> DUE TO <u>776X</u> (c) <u>776X</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>2/16 61</u>	(County)	(State)	21. I certify that (I) (this hospital) attended the deceased from <u>2/16 1961</u> to <u>2/16 61</u> , that (I) (we) last saw the deceased alive on <u>2/16 1961</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>R J Villorri</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>R J Villorri</u>		22d. ADDRESS <u>5th Ward</u>					
23a. (BURIAL) CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		23d. LOCATION (City, town, or county) <u>Lusby, Md</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>P E Sewell</u>		ADDRESS <u>Prince Frederick</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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CENTRAL BANK OF INDIA

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01700

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Earl</i> Middle <i>P</i> Last <i>Morsell</i>		4. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 3</i>
9. AGE (In years last birthday) <i>46</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Tarey Morsell</i>		14. MOTHER'S MAIDEN NAME <i>Amonia Reid</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Amonia Reid, Huntingtown, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>325.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Upper Respir Infection</i> DUE TO (c) <i>Congenital Deafness</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2:15</i> 19 <i>61</i> , to <i>10:00</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>2/5</i> 19 <i>61</i> , and that death occurred at <i>10:00</i> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Page P. Jett</i>		22b. DATE SIGNED <i>2/5/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>PAGE P. JETT</i>		22d. ADDRESS <i>BRUCE FREDERICK</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>2-19-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Plum Point</i>		23d. LOCATION (City, town, or county) (State) <i>Calvert Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Prince Frederick,</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 23 '61</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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